# Case Studies of SBIRT in Action

National SBIRT ATTC
Compendium of Cases

## Case #1: SBIRT for Substance Use in New York City Sexually Transmitted Disease Clinics

*Synopsis of a recorded webinar*

*DATE: August 27, 2014*

**Presenters:**

**Shirley DeStafeno**, NYSBIRT, Project Manager, New York State OASAS

**Meighan Rogers, MPH**, Bureau of STD Control and Prevention New York City DOHMH

**Brett Harris, DrPH,** NYSBIRT Project Evaluator, New York State OASAS

### Overview:

This webinar shares best practices and lessons learned from implementation and evaluation of an SBIRT program that has been rolled out in the eight New York City Department of Health and Mental Hygiene (DOHMH) sexually transmitted disease (STD) clinics. Building on a long term relationship and a demonstrated need to address alcohol and substance use by STD clinic patients, NYS OASAS and NYC DOHMH collaborated to optimize the SBIRT model for STD clinic settings, effectively implement universal SBIRT services, and evaluate program outcomes. This real world example demonstrates the integration of a new set of services in a specialized healthcare setting.

### Patient population served:

The DOHMH STD program serves over 90,000 patients with STD screening and treatment, HIV testing, and other related sexual and reproductive health services. The eight clinics primarily serve walk-in patients; only about 35% of patients return for multiple visits. They are not primary healthcare clinics.

### Content description:

A brief description of SBIRT is followed by a presentation of SBIRT goals and principles in the context of SBIRT's history in New York State, including the history of the SBIRT program in NYC DOHMH STD clinics.

Since risky substance use is closely associated with risky sexual behavior and acquisition of HIV/AIDS and other STDs, the rationale for SBIRT in the STD clinic setting is well established. The SBIRT Service Flow in the clinics is discussed, including exactly where SBIRT fits, depending on the type of patient visit: HIV test only; MD visit only; HIV test and MD visit. The process of recording SBIRT information in the EMR is also described. Additional information presented includes:

- Service delivery results
- Use of Extended Brief Intervention (EBI)
- Patient demographics
- Self-reported behavioral and social outcomes
- Biomedical outcomes (2008-2011)
- Biomedical outcomes related to HIV and other STDs in the 1-year following SBIRT date of visit in STD clinic
- Patient and staff feedback
- Future challenges and needs

### Screens Used:

For pre-screening, the clinics use the AUDIT-C (first three questions of the AUDIT) and the first question of the DAST-10. The pre-screen is self-administered to all patients in the waiting room. The full AUDIT/DAST-10 is administered by the interventionist to patients who have a positive score on the pre-screen.

### Screening Rate:

All patients are asked to fill out the initial SBIRT pre-screen. About 80% do and most of the 20% who don't are return patients who have filled out the pre-screen on previous visits.

### Billing information:

Currently the program is grant-funded through 2016. Options for further funding and/or implementation of billing procedures are being explored.

**Link to Webinar: http://ireta.org/8_27_14webinar**

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## Case #2: Implementing SBIRT in Any Site or Organization

*Synopsis of a recorded webinar*

*DATE: July 23, 2014*


### Presenter:

**Janice L. Pringle, PhD**

Associate Professor, University of Pittsburgh School of Pharmacy; Director, Program Evaluation and Research Unit (PERU)


### Overview:

This webinar covers in detail the basic principles of organizational change that can be used to guide SBIRT implementation in any site or organization, including:

- How to do on site observations and develop an effective implementation plan
- The role of a champion in effectively implementing SBIRT
- Adapting to the site's ever-changing needs and support effective and ongoing implementation
- How to address sustainability

### Patient population served:

No specific patient population is discussed, but an SBIRT vision is articulated: "Every patient receives the correct SBIRT process by the appropriate staff and providers at the right time every time."

### Content description:

The presenter provides practical and comprehensive information about the development of an SBIRT implementation strategy, regardless of the target population or setting. Successful SBIRT implementation is based on the following steps:

- Based on an organizational assessment, evaluate your sites to choose the best ones for initial implementation
- Select your sites based on your own and their potential resources—start small
- When the selection is made, develop an implementation plan based on the following steps:
  1. Conduct a Current Condition/ Business Process Analysis
  2. Develop the implementation plan collaboratively
  3. Follow a "learn, change and improve as you go" model
- Build in sustainability from the outset

### Billing information & Screening Instruments:

Billing information and screening instruments are not discussed.

**Link to Webinar: http://ireta.org/7_23_14webinar**

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## Case #3: SBIRT as part of Project Care: Integrating Behavioral Health Services in Kern County, CA

*Synopsis of a recorded webinar*

*DATE: June 25, 2014*

**Presenters:**

**Lily Alvarez,** Behavioral Health System Administrator, Kern County Mental Health Department

**Christopher Reilly, LMFT,** Behavioral Health Director, Clinica Sierra Vista

**Darren Urada, PhD,** UCLA Integrated Substance Abuse Programs

## Overview:

As more residents gain access to primary care, mental health, and substance use disorder services as a result of the Affordable Care Act, community health centers will need to identify and address more behavioral health issues in their primary medical practice. This webinar demonstrates how a behavioral health managed care company (Kern County Behavioral Health) directs funds from the Mental Health Services Act (a 1% tax on millionaires) to support the provision of behavioral health services in eight Federally-Qualified Health Centers (FQHCs).

## Patient population served:

Kern County's Project Care is serving tens of thousands of patients by bringing behavioral health awareness and treatment to populations of county residents that had not previously considered, understood or otherwise been able to access service through traditional points of entry.

## Content description:

Ms. Alvarez presents an overview of how Kern County supports the integrated healthcare model in the eight FQHCs and one county hospital. She addresses:

- Features (and goals) of healthcare integration (including universal mental health and alcohol use screening)
- Overcoming barriers
- Challenges still to be addressed
- Ongoing infrastructure to support the project

Mr. Reilly describes how the project is working at one of the selected FQHCs, Clinica Sierra Vista. He discusses the following areas:

- The challenges of bringing behavioral health specialists into a community health care setting
- Specific elements of the "culture clash"
- Resolving the "culture clash" by integrating the behavioral health care specialists so that they are utilized frequently and in real time by the medical providers
- Finding the right kind of behavioral health provider and broadening that definition with the funders
- Establishing a sustainable business plan and figuring out in detail how to address fiscal challenges
- Assessing the ongoing viability of the project at Clinica Sierra Vista and elsewhere

Dr. Urada presents evaluation data that measured:

- Staff perceptions of the value of the services provided by the behavior health providers; value of the screening information for the primary care providers; communication between medical and behavioral health staff; whether integration should be recommended to other primary care providers; whether the balance between behavioral health and non-behavioral health patients at the clinic is appropriate
- Overall integration progress
- Screening data
- Planned future and ongoing evaluation

## Screens Used:

PHQ-9, GAD-7 (Generalized Anxiety Disorder 7-item scale), AUDIT-C

## Billing information:

There was considerable discussion of billing in the context of the reimbursement environment in California. But some of the processes discussed to enhance billing opportunities could be applied to situations in other states.

**Link to Webinar: http://ireta.org/6_25_14webinar**

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## Case #4: Lessons in Integrating SBIRT into Family Health Centers: An SBIRT Pilot Program in Orange County, CA

*Synopsis of a recorded webinar*
*DATE: May 7, 2014*

### Presenters:

**Cary Clevenger, LCSW** Service Chief II, Orange County Health Care Agency Quality Review and Training Department and Supervisor of the University of California, Irvine (UCI) SBIRT team

**Emily Dow, MD** Clinical Professor and Vice Chair, Department of Family Medicine at the University of California Irvine and Medical Director for the UC, Irvine Outreach Clinics

**Tawny Moreno, LMFT** Behavioral Health Specialist who is currently co-implementing the SBIRT program at the UCI health center in Santa Ana

**Brett O'Brien, MA, LMFT** Director Children, Youth and Prevention Services Orange County Health Care Agency

**Dirk Zirbel, PhD** Associate Director UC Irvine Family Health Centers

### Overview

Presenters discuss the benefits of and barriers to implementing SBIRT in family healthcare clinics in Orange County, CA. From finding partners to hiring staff to agency protocols and developing a resource directory, they discuss their lessons learned as they work to implement SBIRT.

### Patient Population Served:

Adults 18 and older, largely a low-income, Hispanic population; 67% women, 33% men; 60% age 50 and older, 34% age 26-49, 6% age 18-25. No children or adolescents are screened.

### Content Description:

This webinar presents a detailed description of the integration of behavioral health staff from a county behavioral health services agency into a primary care setting. The goal of the project is to identify patients who are at risk of substance use and mental health disorders, offer brief interventions on site as needed, and referrals to treatment for patients who are more seriously involved. The presenters outline the various administrative hurdles that had to be overcome in order to get the project started, as well as the vigorous and successful efforts that were made to integrate the behavioral health staff into the clinic flow in as seamless a way as possible. In most cases, the behavioral health specialists interact with patients in the exam room before the physician comes in to address the patient's medical needs.

Flexibility is a key factor, since it may mean that the SBIRT session is interrupted while the physical examination is completed then picked up again afterwards. Lessons learned include:

- Personality traits of assigned behavioral health staff are important for the project to succeed
- Behavioral health specialists have to be well trained in the clinic protocols, including how to respond to crises
- Good supervision and staff support is essential
- Attending clinic staff meetings and continuously making themselves known as medical staff changes increases acceptance level of the behavioral health specialists
- Eventually these efforts have led to the behavioral health specialists becoming full and valued members of the clinic team
- Developing tools to support daily tasks and well developed relationships with outside agencies for referrals to treatment are important
- Ongoing barriers and logistical challenges need to be addressed with patience, understanding that systems can take a while to evolve

### Screens Used:

The project has developed a modified SBIRT screening tool that includes the GAD-2, PHQ-2, the AUDIT-C the NIDA pre-screen question, a domestic violence and a trauma question. (All the screens used are available on the IRETA webpage for this webinar).

### Screening Rates:

4,296 patients were screened between July 2013 and February 2014, an average of 530 patients a month. 28% were positive screens; of that number, 86% screened positive for mental health disorders, 9% for substance use, 5% for domestic violence and 9% for multiple issues (mostly mental health and risky substance use).

### Billing information:

This project is funded by mental health dollars available through California Proposition 63, a 1% tax on people whose annual income is $1 million or more.

### Link to Webinar:

**http://ireta.org/ireta.org/5%207%2014webinar**

# Case #5: SBIRT in Action - The Georgia BASICS Program

*Synopsis of a recorded webinar*

*DATE: March 19, 2014*

## Presenter:

**Stephen H. O'Neil, MA** Director of the Ohio Substance Use Screening, Brief Intervention, and Referral to Treatment Project at the Ohio Department of Mental Health and Addiction Services

## Overview

Georgia BASICS (Brief Assessment, Screening, Intervention Continuum of Care System) was part of the third cohort of SBIRT project grantees. The project was implemented within two primary organizations: Grady Health System (GHS) and the Medical Center of Central Georgia (MCCG). The intent of the project was twofold; 1) to increase the proportion of persons receiving SBIRT services in the emergency department and other clinics affiliated with GHS and MCCG and 2) to develop an expanded workforce with SBIRT competencies.

SBIRT services were implemented in the emergency departments of the state's two largest medical facilities. In year three, the project expanded to include selected primary care sites at each hospital.

## Patient Population Served:

Forty percent of patients served were "precariously housed" (without a permanent living situation) and had complex health conditions. During the five years of the project, approximately 2,500 patients were pre-screened each week.

## Content Description:

The webinar begins with a description of the Georgia BASICS project and its structure, delivered primarily at the emergency departments of two large hospitals. The presentation goes on to discuss:

- How the project was staffed, including different staff qualifications for different SBIRT functions
- The overall clinical structure and flow of the screening process itself, including how the EMR triggered the process by notifying staff about patients with positive pre-screens
- The breakdown of how many patients received each SBIRT service beyond screening (i.e. brief intervention, brief treatment, referral to treatment); for example, 25% of patients had a positive pre-screen and received the full screen and other SBIRT services as indicated.
- A detailed outline of how clinical fidelity to the SBIRT model was achieved and maintained
- How the health educators who delivered SBIRT services became an integral part of the emergency department and were identified by patients as hospital "healthcare" staff
- The importance of doing follow-up with patients and how it was done
- Results based on a sample analysis that examined data on:
  - Reduction in risky drinking
  - Reduction in drinking days
  - Increase in abstinence
  - Increased engagement in treatment
  - Improvement in mental health
  - Decreased utilization of the emergency room

The webinar concludes that SBIRT makes a meaningful difference in patients' lives, links them to the care they need (including natural support systems), and is good policy.

## Screens Used:

NIAAA and NIDA pre-screen questions were administered to all patients at intake. The Alcohol, Smoking, and Substance Involvement Screening Test (ASSIST, version 3.1) was administered to all patients who scored positive on the pre-screen.

## Billing information:

No billing information was presented.

## Link to Webinar:

**http://ireta.org/node/921**

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## Case #6: Implementation of SBIRT - Lessons from the Field

*Synopsis of a recorded webinar*

*DATE: February 27, 2014*

### Presenters:


**Aaron Williams, MA**

Director of Training and Technical Associate for Substance Abuse for the SAMHSA-HRSA Center for Integrated Health Solutions at the National Council for Behavioral Health

**Michael Lardieri, LCSW**

Vice President, Health Information Technology and Strategic Development at the National Council for Behavioral Health in Washington, DC (helped develop the materials but did not present)

**Nancy A. Roget, MS, MFT**

Executive Director of CASAT, PI/Project Director of the National Frontier and Rural Addiction Technology Transfer Center


### Overview

This webinar is in two parts. In the first section, Aaron Williams discusses common themes and lessons learned from a multi-site SBIRT implementation project conducted by the National Council for Behavioral Health in Cincinnati, Ohio. In the second section, Nancy Roget presents information about the use of technology-based SBIRT as an effective early intervention strategy.

### Patient Population Served:

The Cincinnati project included students seen in school-based programs, patients at health centers, and clients seen through community anti-drug coalitions. Five settings are referenced in the technology-based section: emergency departments, primary care centers, OB-GYN offices, pediatric offices and school-based health programs.

### Content Description:

Part one of the webinar focuses on four key areas for SBIRT implementation.

- **Workforce development:** Development of skills important to the delivery of SBIRT services
- **Workflow:** Development of a flow chart for the SBIRT process on the individual agency level, with reference to interfacing with the larger community system of care
- **Partnerships:** Understanding the local network and working with the system of care to develop efficient referral mechanisms and relationships
- **Billing:** A discussion of SBIRT billing codes and how the codes relate to the various elements of the SBIRT process. It is important to realize that the use of the codes is rooted in local conditions. Contacting payers about which codes are in place then testing the system are important steps.

Part two of the webinar focuses on SBIRT as a technology-based intervention.

- Recent research underscoring the advantages of computer-based SBIRT is presented, including a discussion of UC Irvine's CASI project (Computerized Alcohol Screening and Intervention) and studies related to computer-based brief interventions with post-partum women at risk for cannabis use, as well as with adolescents in school-based and primary health care settings.
- Information about IVR (Interactive Voice Response) is also presented. IVR uses touchtone phones to enable a caller to interact with a computer using the telephone keypad as the interface. A study showing the benefits of IVR brief interventions is presented and discussed.

### Screens Used:

No specific screens are discussed in this webinar. The UC Irvine CASI project's use of the AUDIT is mentioned.

### Billing information:

Information about billing codes and how to use them is presented in the first part of the webinar as outlined above.

### Link to Webinar:

**http://ireta.org/node/919**